STATE OF ILLINOIS
Department of Central Management Services • Bureau of Benefits

Benefit Choice Options

Enrollment Period May 1 - May 31, 2016 • Effective July 1, 2016

State of Illinois

Benefit Choice Open Enrollment is May 1 - May 31, 2016.

Benefit Choice Period changes must be submitted no later than Tuesday, May 31st! If you do not want to change your coverage, your current coverage will remain in place.

It is each member's responsibility to know their plan benefits and make an informed decision regarding coverage elections.

IMPORTANT: Enrollment in the Medical Care Assistance Plan (MCAP) and/or the Dependent Care Assistance Plan (DCAP) is optional and requires re-enrollment each year. Eligible employees MUST submit a new MCAP and/or DCAP request no later than May 31st in order to be enrolled effective July 1, 2016.

View Online Group Insurance Benefit Statements that show your current coverage.
Go to the Benefits website and click on this button…

Go to the 'Latest News' section of the Benefits website at
www.benefitschoice.il.gov
for group insurance updates throughout the plan year.

Basic Insurance Terms Explained

What is an Insurance Premium?	**Insurance premiums** are the deductions taken out of your paycheck for your part of the insurance cost. In most cases, the State picks up the majority of your premium.

A **copayment** (or copay) is a fixed-dollar amount that you pay each time you have certain medical visits/procedures.	**What is a Copayment?**

What is a Deductible?	The **deductible** is the amount that you must pay toward your medical expenses before your plan will pay for any nonpreventive services.

Coinsurance is your share of the cost for a covered service, calculated as a percentage of the allowed amount for the service. You pay coinsurance after you've met your deductible.	**What is Coinsurance?**

What is an Out-of-Pocket Max (OOP)?	The **OOP** maximum is the most you will pay for eligible medical services and prescription drugs in a plan year. Once you meet your OOP maximum, the plan will pay 100% of eligible services. Coinsurance, copayments and deductibles all apply toward your out-of-pocket maximum.

FY2017 Benefit Choice Period

(Enrollment Period May 1 – May 31, 2016)

The Benefit Choice Period will be **May 1 through May 31, 2016**, for eligible members. Members are employees (full-time employees, part-time employees working 50% or greater and employees on leave of absence), COBRA participants, and annuitants and survivors not enrolled in the Medicare Advantage Program (see the box on page 8 for more information). **Elections will be effective July 1, 2016.**

All Benefit Choice changes should be made on the Benefit Choice Election Form available on the Benefits website. Members should complete the form only if changes are being made.

If you elect to opt out of the state's coverage or to add a dependent, you must give the supporting documentation to your agency/university group insurance representative (GIR). Members may obtain their GIR's name and contact information by either contacting their agency's personnel office or by viewing the GIR listing on the Benefits website located at **www.benefitschoice.il.gov**. Members interested in the Flexible Spending Accounts Program must re-enroll each year during the Benefit Choice Period by completing the MCAP and/or DCAP form found on the website. All forms must be submitted by May 31, 2016.

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Changes You Can Make During the Benefit Choice Period

Members may make the following changes during the Benefit Choice Period:

- Change health plans.
- Add or drop dental coverage. Employees must be enrolled in a health plan in order to have dental coverage. Retirees may opt out of health coverage and remain enrolled in dental coverage.
- Add or drop dependent coverage. **Note:** Survivors may add a dependent only if that dependent was eligible for coverage as a dependent under the original member.
- Add, drop, increase or decrease Member Optional Life insurance coverage.
- Add or drop Child Life, Spouse Life and/or AD&D insurance coverage.
- Elect to opt out (applies only to full-time employees, including those on a leave of absence, annuitants and survivors). All members electing to opt out must provide proof of other comprehensive health coverage. **This election will terminate health, prescription, behavioral health and vision coverage for the member and any enrolled dependents.** Dental coverage for employees will also be terminated; however, annuitants and survivors will remain enrolled in the dental coverage unless they elect to cancel the coverage during the annual Benefit Choice Period.
- Elect to waive health, dental, vision and prescription coverage (part-time employees 50 percent or greater, annuitants and survivors).
- Re-enroll in the Program if previously opted out of or waived coverage. Members have the option of not electing dental coverage upon re-enrollment into the health plan.
- Re-enroll in the Program if coverage is currently terminated due to nonpayment of premium while on leave of absence (employees only – subject to eligibility criteria). Any outstanding premiums plus the July 2016 premium must be paid before coverage will be reinstated. **Note:** Survivors and annuitants are not eligible to re-enroll if previously terminated due to nonpayment of premium.
- Enroll in MCAP and/or DCAP. **Employees must enroll each year; previous enrollment in the program does not continue into the new plan year. Note:** Survivors and annuitants are not eligible for MCAP or DCAP.

Documentation Requirements

- Documentation, including the SSN, is required when adding dependent coverage.
- An approved statement of health is required to add or increase Member Optional Life coverage or to add Spouse Life or Child Life coverage.
- If opting out, proof of other comprehensive health coverage provided by an entity other than the Department of Central Management Services, is required.
- Documentation must be submitted to your GIR no later than June 10.

Transition of Care after Health Plan Change: Members and their dependents who elect to change health plans and are then hospitalized prior to July 1 and are discharged on or after July 1, should contact both the current and future health plan administrators and primary care physicians as soon as possible to coordinate the transition of services.

Members or dependents involved in an ongoing course of treatment or who have entered the third trimester of pregnancy should contact the new plan to coordinate the transition of services for treatment.

COBRA Participants: During the Benefit Choice Period, COBRA participants have the same benefit options available to them as all other members with the exception of life insurance coverage, which is not available to COBRA participants. COBRA health and dental rates for the 2017 plan year will be available on or after May 1, 2016. Any questions, contact COBRA at (217) 558-6194.

Member Responsibilities

You must notify the group insurance representative (GIR) at your employing agency, university or retirement system if:

- **You and/or your dependents experience a change of address.**
- **Your dependent loses eligibility.** Dependents who are no longer eligible under the Group Insurance Program (Program), including divorced spouses or partners of a dissolved civil union or domestic partner relationship, must be reported to your GIR immediately. **Failure to report an ineligible dependent is considered a fraudulent act. Any premium payments you make on behalf of the ineligible dependent which result in an overpayment will not be refunded. Additionally, the ineligible dependent may lose any rights to COBRA continuation coverage.**
- **You go on a leave of absence or have unpaid time away from work.** When you have unpaid time away from work, or are ineligible for payroll deductions, you are still responsible to pay for your group insurance coverage. You should immediately contact your GIR for your options, if any, to make changes to your current coverage. Requested changes will be effective the date of the written request if made within 60 days of beginning the leave. You will be billed by CMS for the cost of your current coverage. **Failure to pay the bill may result in a loss of coverage and/or the filing of an involuntary withholding order through the Office of the Comptroller.**
- **You have or gain other coverage.** If you have group coverage provided by a plan other than the Program, or if you or your dependents gain other coverage during the plan year.
- **You experience a change in Medicare status.** A copy of the Medicare card must be provided to the Medicare Coordination of Benefits Unit at Central Management Services when a change in your or your dependent's Medicare status occurs. **Failure to notify the Medicare Coordination of Benefits Unit of your Medicare eligibility may result in substantial financial liabilities.** The Medicare Unit's address and phone number can be found on page 36.
- **You get married or enter into a civil union partnership; or your marriage, domestic partnership or civil union partnership is dissolved.**
- **You have a baby or adopt a child.**
- **Your employment status changes from full-time to part-time or vice versa, or the employment status of your dependent changes.**
- **You have a financial or medical power of attorney (POA) who you would like to be able to make decisions and get information on your behalf if you are incapacitated.**
  - **Financial POA – used by your agent to change your health plan elections.** The financial POA document would allow an agent to make health, dental and life insurance plan elections on your behalf and should be sent to your agency or retirement system group insurance representative.
  - **Medical POA – used by your agent to speak with your health, dental and vision plans about your coverage and claims.** A medical POA generally gives an agent the authority to make medical decisions on your behalf; therefore, in order for your agent to speak with your health, dental and/or vision plan(s), you would need to submit the medical POA document to each plan for them to have on file.

Contact your GIR if you are uncertain whether or not a life-changing event needs to be reported.

What You Should Know for Plan Year 2017

- **Federal Healthcare Reform:** As a result of the Affordable Care Act (ACA), prescription deductibles and copayments paid by members apply toward the annual out-of-pocket maximum. Once the maximum has been met, eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year. The out-of-pocket maximum amount for each type of health plan varies and is outlined on page 12.
- **Annuitant and Survivor Opt Out Option:** Annuitants and survivors electing to opt out of the health coverage (which includes the termination of health, behavioral health, vision and prescription drug coverage) will remain enrolled in the dental and life insurance coverage. Annuitants and survivors who opt out of the health coverage and do not want the dental coverage, must indicate they do not want the dental coverage. Further information regarding opt out programs is available on page 9.
- **Medical Care Assistance Plan (MCAP) Rollover:** The MCAP maximum contribution amount will remain $2,550 for the 2017 plan year with a $500 maximum rollover. Employees must re-enroll in MCAP for the new plan year in order to qualify for the rollover. Those who do not re-enroll will forfeit any amount eligible for rollover.

Be a Good Consumer - Optimize Your Benefits!

In order to get the most savings from all of your benefit plans, be sure to:

- **Check with Your Doctor BEFORE having Tests/Procedures Performed.** Research the provider networks of your health, prescription, behavioral health, dental and vision plans. All the plan administrators have contracted provider networks that can **optimize your benefits** and save you money. Out-of-network services can cost you considerably more money, especially fees over the plans allowable charges.
- **Choose generics.** If you take any medications, make sure to choose generics whenever possible. Check to see if your prescription is on the formulary list, or ask your doctor before leaving the office.

Member and Dependent Monthly Contributions

Full-time Employee Monthly Health Plan Contributions*

While the State covers most of the cost of employee health coverage, employees must also make a monthly salary-based contribution. Employees who retire, accept a voluntary salary reduction or return to State employment at a different salary may have their monthly contribution adjusted based upon the new salary (this applies to employees who return to work after having a 10-day or greater break in State service after terminating employment – this does not apply to employees who have a break in coverage due to a leave of absence).

Employee Annual Salary	Employee Monthly Health Plan Contributions Amounts	
$30,200 & below	Managed Care: $68	Quality Care: $93
$30,201 - $45,600	Managed Care: $86	Quality Care: $111
$45,601 - $60,700	Managed Care: $103	Quality Care: $127
$60,701 - $75,900	Managed Care: $119	Quality Care: $144
$75,901 - $100,000	Managed Care: $137	Quality Care: $162
$100,001 & above	Managed Care: $186	Quality Care: $211

Dependent Monthly Health Plan Contributions*

The monthly dependent contribution for the 2017 plan year is in **addition** to the member health plan contribution. Dependents must be enrolled in the same plan as the member. **The Medicare dependent contribution applies only if Medicare is PRIMARY for both Parts A and B.** Members with questions regarding Medicare status may contact the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit at (800) 442-1300 or (217) 782-7007.

Health Plan Name and Code	One Dependent	Two or more Dependents	One Medicare A and B Primary Dependent	Two or more Medicare A and B Primary Dependents
BlueAdvantage HMO (Code: CI)	$ 96	$132	$ 75	$110
Coventry HMO (Code: AS)	$111	$156	$ 88	$130
Coventry OAP (Code: CH)	$111	$156	$ 88	$130
Health Alliance HMO (Code: AH)	$113	$159	$ 89	$133
HealthLink OAP (Code: CF)	$126	$179	$102	$149
HMO Illinois (Code: BY)	$100	$139	$ 79	$116
Quality Care Health Plan (Code: D3)	$249	$287	$142	$203

Member Monthly Quality Care Dental Plan (QCDP) Contributions*

Member Only	$11.00	Member plus 1 Dependent	$17.00	Member plus 2 or more Dependents	$19.50

* Part-time employees are required to pay a percentage of the State's portion of the contribution in addition to the member contribution. Special rules apply for non-IRS dependents (see the Benefits website for more information).

Member and Dependent Monthly Contributions

Retiree, Annuitant and Survivor Monthly Health Plan Contributions	
20 years or more of creditable service	$0.00
Less than 20 years of creditable service and, • SERS/SURS annuitant/survivor on or after 1/1/98, or • TRS annuitant/survivor on or after 7/1/99	Five percent (5%) of the costs of the basic program of group health benefits for each year of service less than 20 years.

Call the appropriate retirement system for applicable premiums.
SERS: (217) 785-7444; SURS: (800) 275-7877; TRS: (800) 877-7896

Monthly Life Plan Contributions

Optional Term Life Rate	
Member by Age	Monthly Rate Per $1,000
Under 30	$0.06
Ages 30 - 34	0.08
Ages 35 - 44	0.10
Ages 45 - 49	0.16
Ages 50 - 54	0.24
Ages 55 - 59	0.44
Ages 60 - 64	0.66
Ages 65 - 69	1.28
Ages 70 and above	2.06

Spouse Life Monthly Rate	
Spouse Life $10,000 coverage (Annuitants under age 60 and Employees)	6.00
Spouse Life $5,000 coverage (Annuitants age 60 and older)	3.00

AD&D Monthly Rate Per $1,000	
Accidental Death & Dismemberment	0.02

Child Life Monthly Rate	
Child Life $10,000 coverage	0.70

Special Notice Regarding 2017 Plan Year Premiums

The premium levels listed in this benefits book are for FY 2016 (July 1, 2015 – June 30, 2016). Personnel should be aware that these premiums may be subject to an increase, pending the outcome of an ongoing legal dispute between the State and AFSCME and that this premium increase may be applied retroactively to July 1, 2016. In other words, once the legal dispute is resolved, a higher premium likely will apply – not only going forward, but also for the period from July 1, 2016, to the date of the increase. For bargaining unit employees, your Union has the full details regarding the State's proposal. Unless another manner of retroactive payment of the premiums owed is negotiated with your Union, the increased premium difference owed for the period from July 1, 2016, through the date of the increase will be deducted on a pro rata basis out of the paychecks remaining in the fiscal year. This means that there will be two deductions for health insurance from an employee's paycheck once the increase has been set: one deduction at the new rate and a second deduction to make up what is owed for the prior period (i.e., the difference between the prior rate and the new rate). By electing coverage under this group health plan, an employee is consenting to all such payroll deductions. Employees represented by unions that have already ratified their agreements will not have any premium increases applied retroactively. Those employees represented by unions that have not yet ratified agreements should contact their union representatives to determine whether such increases may be applied retroactively.

Health Plan

The State of Illinois offers its employees, annuitants and survivors health benefits through the State Employees Group Insurance Program (health includes medical, prescription and behavioral health coverage). Vision coverage is included at no additional cost when enrolled in a health plan. With limited exceptions, the State makes monthly contributions toward your health premiums. Active employees, annuitants and survivors should refer to pages 6-7 for the monthly contribution amounts.

As an employee, annuitant or survivor of the State, you are offered various health insurance coverage options:

- **Quality Care Health Plan (QCHP)**
- **Managed Care Plans** (two types)
  - Health Maintenance Organizations (HMOs)
  - Open Access Plans (OAPs)

The health insurance options differ in the benefit levels they provide, the doctors and hospitals you can access and the cost to you. See the Benefits Comparison charts on pages 14-16 for information to help you determine which plan is right for you.

Full-time employees, retirees, annuitants and survivors have the **option to opt out** of health coverage if they have other comprehensive health coverage provided by an entity other than the Department of Central Management Services. Full-time employees who do not have other comprehensive health coverage must remain enrolled in the State's health plan.

Full-time employees who elect to opt out will have their health, dental, vision, behavioral health and prescription coverage terminated. **Annuitants and survivors** who opt out without the financial incentive will have all coverage terminated, except dental and life insurance. Annuitants and survivors who do not want the dental coverage may only cancel the coverage during a Benefit Choice Period. See page 9 for more information regarding opting out.

Part-time employees, retirees, annuitants and survivors have the **option to waive** all coverage which will terminate health, dental, vision, behavioral health and prescription drug coverage. Members electing to waive coverage do not need to provide proof of other coverage.

If you change health plans during the Benefit Choice Period, or re-elect health coverage after opting out or waiving coverage, your new health insurance ID cards will be mailed to you directly from your health insurance carrier, not from the Department of Central Management Services. If you need to have services but have not yet received your ID cards, contact your health insurance carrier.

Except for annuitants and survivors who become enrolled in Medicare Parts A and B prior to October 1, 2016, members who select a health plan during the Benefit Choice Period will remain in that plan the entire plan year unless they experience a qualifying change in status that allows them to change plans.

Total Retiree Advantage Illinois (TRAIL)
Medicare Advantage Program

Annuitants and survivors who become enrolled in Medicare Parts A and B and meet all the criteria for enrollment in the Medicare Advantage Program will be notified of the TRAIL Open Enrollment Period by the Department of Central Management Services. These members will be required to choose a Medicare Advantage plan or opt out of all State coverage, except dental and life, in the fall with an effective date of January 1, 2017. Opting out will terminate health, behavioral health, prescription and vision coverage. For more information regarding the Medicare Advantage 'TRAIL' Program, go to:

www.cms.illinois.gov/thetrail

Opt Out and Annuitant Waiver

Opt Out

In accordance with Public Act 92-0600, full-time employees, retirees, annuitants and survivors may elect to Opt Out of the State Employees Health Insurance Program (Program) if proof of other major medical insurance by an entity other than the Department of Central Management Services is provided. **This election will terminate health, prescription, behavioral health and vision coverage for the member and any enrolled dependents.** Dental coverage for employees will also be terminated; however, annuitants and survivors will remain enrolled in the dental coverage unless they elect to cancel the coverage during the annual Benefit Choice Period.

Members opting out of the Program continue to be enrolled with the same Basic and Optional Life insurance coverage, if applicable.

If you opt out of the Program you will **not be eligible** for the:

- Free influenza immunizations offered annually
- COBRA continuation of coverage
- Smoking Cessation Benefit
- Weight-Loss Benefit

However, if you are an employee, you will **still be eligible** for the:

- Flexible Spending Account (FSA) Program
- Commuter Savings Program (CSP)
- Paid maternity/paternity benefit, if eligible
- Employee Assistance Program
- Adoption Benefit Program

Opt Out With Financial Incentive

Applies to SERS, JRS, GARS, SURS and TRS Annuitants who are not currently eligible for Medicare

In accordance with Public Act 98-0019, members not eligible for Medicare who are receiving a retirement annuity from any of the five state retirement systems and who are enrolled in the State Employees Health Insurance Program and have other comprehensive medical coverage may elect to OPT OUT of the health insurance program and receive a financial incentive. Opting out when eligible for the financial incentive, includes health, dental, vision, prescription and behavioral health coverage for the annuitant and any dependents. Make sure to select the 'Opt Out' with Financial Incentive option if you are interested in opting out. The retirement system responsible for your group insurance enrollment will send you additional forms to complete that are required for this election. Members with less than 20 years of creditable service are eligible for a $150/month financial incentive; members with 20 years or more of creditable service are eligible for a $500/month financial incentive. **Members receiving the financial incentive are required to annually recertify with CMS each July that they have other coverage. Note:** Annuitants who retired under TRS cannot count the time worked for a public school district in their creditable service time for financial incentive purposes.

Annuitant Waiver

Public Act 93-553 allows annuitants who are currently enrolled as a dependent of their State-covered spouse to remain a dependent and waive coverage in their own right, thereby decreasing the cost of coverage for an annuitant with less than 20 years of service.

New annuitants who have been enrolled for a year or more as a dependent and wish to remain enrolled as a dependent once becoming an annuitant must indicate on the Participation Election Form (provided by the retirement system) their desire to waive health, dental and vision coverage as an annuitant. The annuitant's spouse cannot carry Spouse Life on the annuitant; however, the annuitant will have Basic Life coverage and may apply for additional Optional Life coverage, if eligible.

Re-enrolling in the Health Plan

Individuals who opt out or waive under any of these Public Acts may re-enroll in the Program only during an annual open enrollment period or within 60 days of experiencing an eligible qualifying change in status. Any outstanding premiums must be paid before you will be allowed to re-enroll. **Note:** Survivors and annuitants are not eligible to re-enroll if previously terminated for nonpayment of premium.

Health Plan Descriptions

There are several health plans available based on geographic location. All plans offer comprehensive benefit coverage. Health maintenance organizations (HMOs) have limitations including geographic availability and defined provider networks, whereas the two open access plans (OAPs) and the Quality Care Health Plan (QCHP) have nationwide networks of providers available to their members.

All health plans require a determination of medical appropriateness prior to specialized services being rendered. HMO plans require the member to obtain a copy of the authorized referral prior to services being rendered. For QCHP and OAPs, it is the member's responsibility to confirm authorization of medical services has been obtained by the health plan provider to avoid penalties or nonpayment of services. Important note: OAPs are self-referral plans. It is the member's responsibility to ensure that the provider and/or facility from which they are receiving services are in either the Tier I or Tier II network to avoid significant out-of-pocket costs. For more detailed information, refer to each health plan's summary plan document (SPD).

Quality Care Health Plan (QCHP)

QCHP is the medical plan that offers a comprehensive range of benefits. Under the QCHP, plan participants can choose any physician or hospital for medical services; however, plan participants receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a QCHP network provider. **Preventive care is paid at 100 percent without having to meet the annual deductible when services are obtained through a network provider.**

Plan participants can access plan benefit and participating QCHP network information, explanation of benefits (EOB) statements and other valuable health information online.

The QCHP has a nationwide network that consists of physicians, hospitals and ancillary providers. Notification to Cigna is required for certain medical services in order to avoid penalties. Contact Cigna at (800) 962-0051 for direction.

QCHP utilizes Magellan for behavioral health benefits and CVS/caremark for prescription benefits. **There is a $125 prescription deductible that applies to each plan participant.**

Managed Care Plans

- **Health Maintenance Organizations (HMOs)**

  Members who elect an HMO plan will need to select a primary care physician (PCP) from a network of participating providers. A PCP can be a family practice, general practice, internal medicine, pediatric or an OB/GYN physician. The PCP will direct all healthcare services and will make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, only a copayment will apply. There are no annual plan deductibles for medical services obtained through an HMO. **Preventive care is paid at 100 percent when services are obtained through a network provider.**

  The minimum level of HMO coverage provided by all plans is described on page 14. Please note that some HMOs provide additional coverage, over and above the minimum requirements. **There is a $100 prescription deductible that applies to each plan participant.**

  If a member is enrolled in an HMO and their PCP leaves the HMO plan's network, the member must choose another PCP within that plan. Alternatively, if CMS determines the plan's network experienced a significant change in the number of medical providers offered, the member may change health plans (the request to change health plans must be elected within 60 days of the qualifying event).

Health Plan Descriptions (cont.)

Managed Care Plans

- **Open Access Plans (OAPs)**

Open access plans combine similar benefits of an HMO with the same type of coverage benefits as a traditional health plan. Members who elect an OAP will have three tiers of providers from which to choose to obtain services. The benefit level is determined by the tier in which the healthcare provider is contracted. Members enrolled in an OAP can mix and match providers and tiers. **Preventive care is paid at 100 percent without having to meet the annual deductible when services are obtained through a Tier I or Tier II network provider.**

There is a $100 prescription deductible that applies for each plan participant regardless of the tier used.

- ✦ Tier I offers a managed care network which provides enhanced benefits. Tier I benefits mirror HMO plan benefits.
- ✦ Tier II offers another managed care network in addition to the managed care network offered in Tier I and also provides enhanced benefits. Tier II requires copayments, coinsurance and is subject to an annual plan year deductible.
- ✦ Tier III covers all providers which are not in the managed care networks of Tiers I or II (i.e., out-of-network providers). Using Tier III can offer members flexibility in selecting healthcare providers, but involve higher out-of-pocket costs. Tier III has a higher plan year deductible and has a higher coinsurance amount than Tier II services. In addition, certain services, such as preventive/wellness care, are not covered when obtained under Tier III. Furthermore, plan participants who use out-of-network providers will be responsible for any amount that is over and above the charges allowed by the plan for services (i.e., allowable charges), which could result in substantial out-of-pocket costs. When using out-of-network providers, it is recommended that the participant obtain preauthorization of benefits to ensure that medical services/stays will meet medical necessity criteria and will be eligible for benefit coverage.

Members who use providers in Tiers II and III will be responsible for the plan year deductible. **In accordance with the Affordable Care Act, these deductibles will accumulate separately from each other and will not 'cross accumulate.'** This means that amounts paid toward the deductible in one tier will not apply toward the deductible in the other tier.

Minimum level benefits are described on page 15 and may also be found in the summary plan document (SPD) on the OAP administrator's website.

Out-of-Pocket Maximum

After the out-of-pocket maximum has been satisfied, the plan will pay 100 percent of covered expenses for the remainder of the plan year. Charges that apply toward the out-of-pocket maximum for each type of plan varies and are outlined in the chart below.

In accordance with the Affordable Care Act (ACA), prescription deductibles and copayments paid by members will also apply toward the out-of-pocket maximum; therefore, once the out-of-pocket maximum has been met, eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year.

The following are the types of charges that apply to the out-of-pocket maximum by plan type:

- **Quality Care Health Plan:**
  - Annual medical plan year deductible
  - Annual prescription plan year deductible
  - Prescription copayments
  - Medical coinsurance
  - QCHP additional medical deductibles

Eligible charges for in-network and out-of-network services will accumulate separately and will not cross accumulate.

- **HMO Plans:**
  - Annual prescription plan year deductible
  - Medical and prescription copayments
  - Medical coinsurance

- **OAP Plans (only applies to Tier I and Tier II providers):**
  - Annual medical plan year deductible (Tier II)
  - Annual prescription plan year deductible
  - Medical and prescription copayments
  - Medical coinsurance

Eligible charges from Tiers I and II will be added together when calculating the out-of-pocket maximum. **Tier III does not have an out-of-pocket maximum.**

Certain charges are always the member's responsibility and do not count toward the out-of-pocket maximum, nor are they covered after the out-of-pocket maximum has been met. Charges that do not count toward the out-of-pocket maximum include:

- The dispense as written (DAW) penalty (i.e., the cost difference between a brand medication and a generic medication, plus the brand copayment, when a generic medication is available);
- Amounts over allowable charges for the plan;
- Noncovered services;
- Charges for services deemed to be not medically necessary; and
- Penalties for failing to precertify/provide notification.

CHARGES THAT APPLY TOWARD OUT-OF-POCKET MAXIMUM

PLAN	Out-of-Pocket Maximum Limits	Annual Plan Year Deductible	Additional Deductibles (QCHP)/ Copayments	Medical Coinsurance	Pharmacy Deductible/ Copayments	Amounts over Allowable Charges (QCHP out-of-network providers and OAP Tier III providers)
QCHP	In-Network Individual $1,500 Family $3,750	X	X	X	X	Amounts over the plan's allowable charges are the member's responsibility and do not go toward the out-of-pocket maximum.
	Out-of-Network Individual $6,000 Family $12,000	X	X	X	X	
HMO	Individual $3,000 Family $6,000	N/A	X	X	X	
OAP Tier I	Individual $6,600 Family $13,200 Tier I and Tier II charges combined	N/A	X	X	X	
OAP Tier II		X	X	X	X	
OAP Tier III	N/A	N/A	N/A	N/A	N/A	

Note: Eligible charges for medical, behavioral health and prescription drugs that the member pays toward the plan year deductibles (medical and prescription), as well as plan copayments and/or coinsurance will be added together for the out-of-pocket maximum calculation. OAP Tier III does not have an out-of-pocket maximum.

Map of Health Plans by Illinois County

July 1, 2016 through June 30, 2017

Refer to the code key below for the health plan code for each plan by county.

BlueAdvantage HMO CI
Coventry HMO. . . . . AS
Coventry OAP . . . . . CH
Health Alliance HMO . . . AH
HealthLink OAP . . . . . CF
HMO Illinois . . . . . BY
Quality Care Health Plan (QCHP) D3

AH, AS, BY, CF, CH, CI, D3

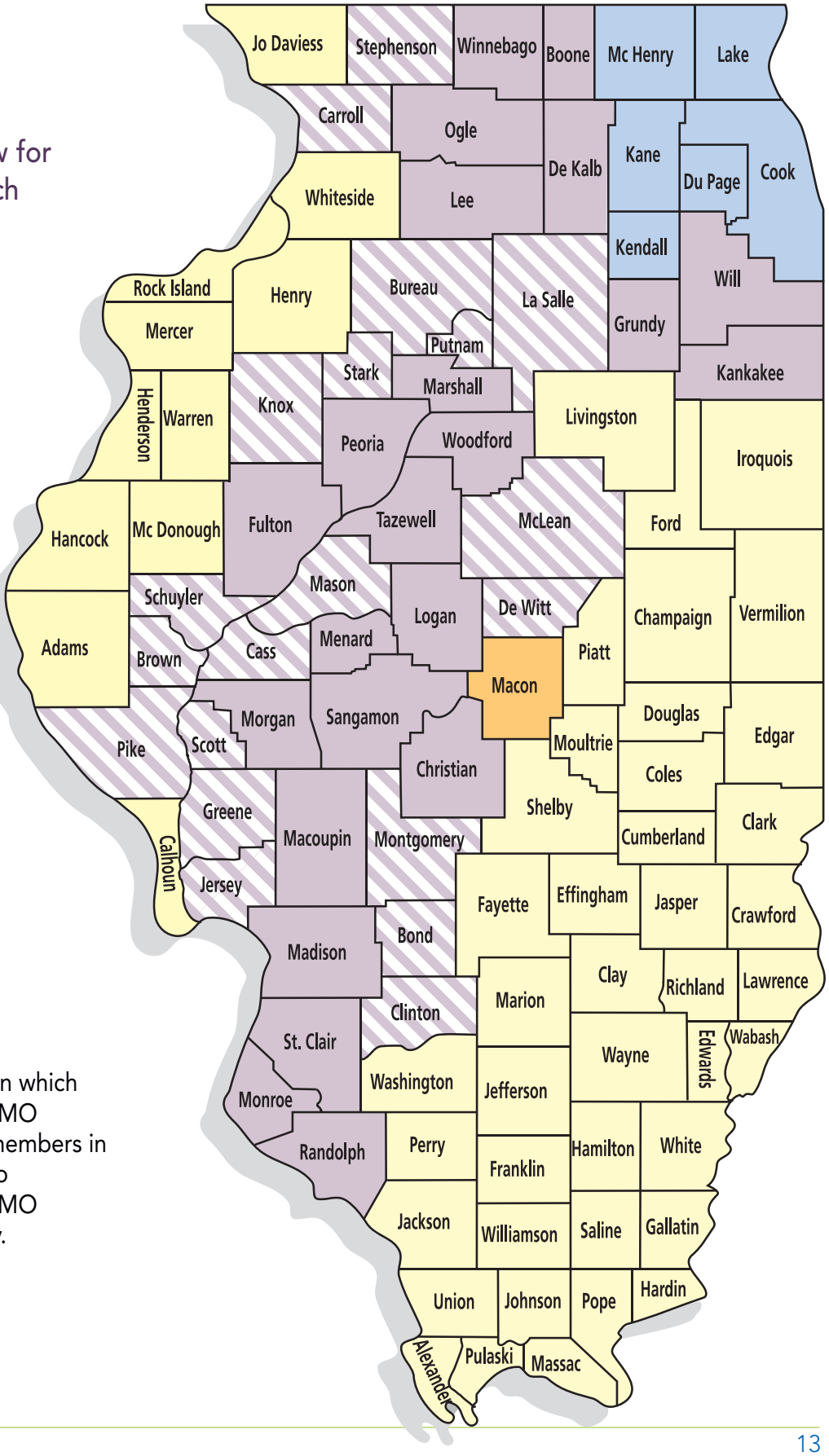
BY, CF, CH, CI, D3

AH, AS, CF, CH, D3

AH, AS, CF, CH, CI, D3

AH, AS, BY, CI, CH, CF, D3

Striped areas represent counties in which HMO Illinois or BlueAdvantage HMO do not have provider coverage; members in these counties may have access to HMO Illinois or BlueAdvantage HMO providers in a neighboring county.



HMO Benefits

The HMO coverage described below represents the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan for a copy of the SPD. A $100 prescription deductible applies to each plan participant (see page 25 for details).

HMO Plan Design	
Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited
Hospital Services	
Inpatient hospitalization	100% after $350 copayment per admission
Alcohol and substance abuse	100% after $350 copayment per admission
Psychiatric admission	100% after $350 copayment per admission
Outpatient surgery	100% after $250 copayment
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after $250 copayment per visit
Professional and Other Services (Copayment not required for preventive services)	
Physician Office visit	100% after $20 copayment per visit
Preventive Services, including immunizations	100%
Specialist Office visit	100% after $30 copayment per visit
Well Baby Care (first year of life)	100%
Outpatient Psychiatric and Substance Abuse	100% after $20 or $30 copayment per visit
Prescription drugs (30-day supply) ($100 deductible applies; formulary is subject to change during plan year)	$8 copayment for generic $26 copayment for preferred brand $50 copayment for nonpreferred brand
Durable Medical Equipment	80%
Home Health Care	$30 copayment per visit

Some HMOs may have benefit limitations based on a calendar year.

Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage available in an OAP. Benefits are outlined in the plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact the plan for a copy of the SPD. A $100 prescription deductible applies to each plan participant (see page 25 for details).

Benefit	Tier I 100% Benefit	Tier II 90% Benefit	Tier III (Out-of-Network) 60% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Max Per Individual Enrollee Per Family	$6,600 (includes eligible charges from Tier I and Tier II combined) $13,200 (includes eligible charges from Tier I and Tier II combined)		Not Applicable
Annual Plan Deductible (must be satisfied for all services)	$0	$250 per enrollee*	$350 per enrollee*
Hospital Services			
Inpatient	100% after $350 copayment per admission	90% of network charges after $400 copayment per admission	60% of allowable charges after $500 copayment per admission
Inpatient Psychiatric	100% after $350 copayment per admission	90% of network charges after $400 copayment per admission	60% of allowable charges after $500 copayment per admission
Inpatient Alcohol and Substance Abuse	100% after $350 copayment per admission	90% of network charges after $400 copayment per admission	60% of allowable charges after $500 copayment per admission
Emergency Room	100% after $250 copayment per visit	100% after $250 copayment per visit	100% after $250 copayment per visit
Outpatient Surgery	100% after $250 copayment per visit	90% of network charges after $250 copayment	60% of allowable charges after $250 copayment
Diagnostic Lab and X-ray	100%	90% of network charges	60% of allowable charges
Physician and Other Professional Services (Copayment not required for preventive services)			
Physician Office Visits	100% after $20 copayment	90% of network charges	60% of allowable charges
Specialist Office Visits	100% after $30 copayment	90% of network charges	60% of allowable charges
Preventive Services, including immunizations	100%	100%	Covered under Tier I and Tier II only
Well Baby Care (first year of life)	100%	100%	Covered under Tier I and Tier II only
Outpatient Psychiatric and Substance Abuse	100% after $20 or $30 copayment	90% of network charges	60% of allowable charges
Other Services			
Copayments (30-day supply)	Prescription Drugs – $100 deductible applies Generic $8	Preferred Brand $26	Nonpreferred Brand $50
Durable Medical Equipment	80% of network charges	80% of network charges	60% of allowable charges
Skilled Nursing Facility	100%	90% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	90% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after $30 copayment	90% of network charges	Covered under Tier I and Tier II only

* An annual plan deductible must be met before Tier II and Tier III plan benefits apply. Benefit limits are measured on a plan year basis.

The Quality Care Health Plan (QCHP)

Plan Year Maximums and Deductibles		
Plan Year and Lifetime Maximum	Unlimited	
Employee's Annual Salary (based on each employee's annual salary as of April 1st)	Individual Plan Year Deductible	Family Plan Year Deductible Cap
$60,700 or less	$375	$937
$60,701 - $75,900	$475	$1,187
$75,901 and above	$525	$1,312
Retiree/Annuitant/Survivor	$375	$937
Dependents	$375	N/A
Additional Deductibles* * These are in addition to the plan year deductible.	Each emergency room visit QCHP hospital admission Non-QCHP hospital admission	$450 $100 $500

Out-of-Pocket Maximum Limits			
In-Network Individual	In-Network Family	Out-of-Network Individual	Out-of-Network Family
$1,500	$3,750	$6,000	$12,000

Hospital Services	
QCHP Hospital Network	$100 deductible per hospital admission. 85% after annual plan deductible.
Non-QCHP Hospitals	$500 deductible per hospital admission. 60% of allowable charges after annual plan deductible.

Outpatient Services	
Preventive Services, including immunizations	100% in-network, 60% of allowable charges out-of-network, after annual plan deductible.
Diagnostic Lab/X-ray	85% in-network, 60% of allowable charges out-of-network, after annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	
Licensed Ambulatory Surgical Treatment Centers	

Professional and Other Services	
Services included in the QCHP Network	85% after the annual plan deductible.
Services not included in the QCHP Network	60% of allowable charges after the annual plan deductible.
Chiropractic Services – medical necessity required (up to a maximum of 30 visits per plan year)	85% in-network, 60% of allowable charges out-of-network, after the annual plan deductible.

Transplant Services	
Organ and Tissue Transplants	85% after $100 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator, Cigna. To assure coverage, the transplant candidate must contact Cigna prior to beginning evaluation services.

Prescription Drugs		
Plan Year Pharmacy Deductible		$125
Copayments (30-day supply)	Generic	$10
	Preferred Brand	$30
	Nonpreferred Brand	$60

Quick Reference Guide for Preventive Health Coverage

Under the Affordable Care Act, you and your family are eligible for some important preventive services which can help you avoid illness and improve your health at no additional cost to you.

What This Means for You

The Affordable Care Act, the health insurance reform legislation passed by Congress and signed into law by President Obama on March 23, 2010, helps make prevention affordable and accessible for all Americans by requiring health plans to cover preventive services at 100 percent and eliminating cost sharing for those services. Preventive services that have strong scientific evidence of their health benefits must be covered and plans can no longer charge a patient a copayment, coinsurance or deductible for these services when they are delivered by a network provider. If you are eligible for a preventive service due to age or medical history, you may have access to preventive services at no cost such as:

- Blood pressure, diabetes and cholesterol tests.
- Many cancer screenings, including mammograms and colonoscopies.
- Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression and reducing alcohol use.
- Routine vaccinations against diseases such as measles, polio or meningitis.
- Flu and pneumonia shots.
- Counseling, screening and vaccines to ensure healthy pregnancies.
- Regular well-baby and well-child visits, from birth to age 21.

Some Important Details

Things to know about preventive care and services:

- **Network providers:** If your health plan uses a network of providers, be aware that health plans are required to provide these preventive services at no charge to you when an in-network provider is used. Your health plan may allow you to receive these services from an out-of-network provider, but may charge you a fee.
- **Office visit fees:** Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay all or a portion of costs of the office visit if the preventive service is not the primary purpose of the visit or if your doctor bills you for the preventive services separately from the office visit.
- **Talk to your healthcare provider:** To know which covered preventive services are right for you, based on your age, gender and health status, ask your healthcare provider.
- **Questions:** If you have questions about whether these new provisions apply to your plan, contact your plan administrator.

This document does not guarantee coverage for all preventive services. Specific terms of coverage, exclusions and limitations are included in the plan administrator's summary plan document.

Wellness Exams & Immunizations

SERVICE	GROUP	AGE, FREQUENCY
Well-baby/well-child/well-person exams, including annual well-woman exam (includes height, weight, head circumference, BMI, blood pressure, history, anticipatory guidance, education regarding risk reduction, psychosocial/behavioral assessment)	● ● ●	• Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months • Additional visit at 2–4 days for infants discharged less than 48 hours after delivery • Ages 3 to 21, once a year • Ages 22 and older, periodic visits, as doctor advises

The following routine immunizations are currently designated preventive services

SERVICE	SERVICE
Diphtheria, Tetanus Toxoid and acellular pertussis (DTaP, Tdap, Td)	Meningococcal (MCV)
Haemophilus influenzae type b conjugate (Hib)	Pneumococcal (pneumonia)
Hepatitis A (Hep A)	Poliovirus (IPV)
Hepatitis B (Hep B)	Rotavirus (RV)
Human papillomavirus (HPV) (age and gender criteria apply depending on vaccine brand)	Varicella (chickenpox)
Influenza vaccine	Zoster (shingles)
Measles, mumps and rubella (MMR)	

You may view the immunization schedules on the CDC website: **cdc.gov/vaccines/schedules/**.

Health Screenings & Interventions

SERVICE	GROUP	AGE, FREQUENCY
Alcohol misuse screening	● ● ●	All adults; adolescents at risk
Anemia screening	●	Pregnant women
Aspirin to prevent cardiovascular disease[1]	● ●	Men ages 45–79; women ages 55–79
Autism screening	●	18, 24 months
Bacteriuria screening	●	Pregnant women
Breast cancer screening (mammogram)	●	Women ages 40 and older, every 1–2 years
Breast-feeding support/counseling, supplies[2]	●	During pregnancy and after birth
Cervical cancer screening (Pap test) HPV DNA test with Pap test	●	Women ages 21–65, every 3 years Women ages 30–65, every 5 years
Chlamydia screening	●	Sexually active women ages 24 and under and older women at risk
Cholesterol/lipid disorders screening	● ● ●	• Screening of children and adolescents ages 9-11 years and 18-21 years; children and adolescents with risk factors ages 2-8 and 12-16 years • All men ages 35 and older, or ages 20–35 if risk factors • All women ages 45 and older, or ages 20–45 if risk factors
Colon cancer screening	● ●	The following tests will be covered for colorectal cancer screening, ages 50 and older: • Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually • Flexible sigmoidoscopy every 5 years • Double-contrast barium enema (DCBE) every 5 years • Colonoscopy every 10 years • Computed tomographic colonography (CTC)/virtual colonoscopy every 5 years - Requires precertification

● = Men ● = Women ● = Children/adolescents

Health Screenings & Interventions

SERVICE	GROUP	AGE, FREQUENCY
Congenital hypothyroidism screening	🟢	Newborns
Critical congenital heart disease screening	🟢	Newborns before discharge from hospital
Contraception counseling/education. Contraceptive products and services[1,3,4]	🟣	Women with reproductive capacity
Depression screening	🔵🟣🟢	Ages 11–21, All adults
Developmental screening	🟢	Newborn 1, 2, 4, 6, 12, 15, 24 months. At each visit ages 3 to 21
Diabetes screening	🔵🟣	Adults with sustained blood pressure greater than 135/80
Discussion about potential benefits/risk of breast cancer preventive medication[1]	🟣	Women at risk
Dental caries prevention (evaluate water source for sufficient fluoride; if deficient prescribe oral fluoride[1])	🟢	Children older than 6 months
Domestic and interpersonal violence screening	🟣	All women
Fall prevention in older adults (physical therapy, vitamin D supplementation[1])	🔵🟣	Community-dwelling adults ages 65 and older with risk factors
Folic acid supplementation[1]	🟣	Women planning or capable of pregnancy
Genetic counseling/evaluation and BRCA1/BRCA2 testing	🟣	Women at risk • Genetic counseling must be provided by an independent board-certified genetic specialist prior to BRCA1/BRCA2 genetic testing • BRCA1/BRCA2 testing requires precertification
Gestational diabetes screening	🟣	Pregnant women
Gonorrhea screening	🟣	Sexually active women age 24 years and younger and older women at risk
Hearing screening (not complete hearing examination)	🟢	All newborns by 1 month. Ages 4, 5, 6, 8, and 10 or as doctor advises
Healthy diet and physical activity counseling	🔵🟣🟢	Ages 6 and older - to promote improvement in weight status. Overweight or obese adults with risk factors for cardiovascular disease
Hemoglobin or hematocrit	🟢	12 months
Hepatitis B screening	🟣	Pregnant women
Hepatitis C screening	🔵🟣	Adults at risk; one-time screening for adults born between 1945 and 1965
HIV screening and counseling	🔵🟣🟢	Pregnant women; adolescents and adults 15 to 65 years; younger adolescents and older adults at risk; sexually active women, annually
Iron supplementation[1]	🟢	6–12 months for children at risk
Lead screening	🟢	12, 24 months
Lung cancer screening (low-dose computed tomography)	🔵🟣	Adults ages 55 to 80 with 30 pack-year smoking history, and currently smoke, or have quit within the past 15 years.
Metabolic/hemoglobinopathies (according to state law)	🟢	Newborns
Obesity screening/counseling	🔵🟣🟢	Ages 6 and older, all adults
Oral health evaluation/assess for dental referral	🟢	12, 18, 24, 30 months. Ages 3 and 6

🔵 = Men 🟣 = Women 🟢 = Children/adolescents

Health Screenings & Interventions

SERVICE	GROUP	AGE, FREQUENCY
Osteoporosis screening	●	Age 65 or older (or under age 65 for women with fracture risk as determined by Fracture Risk Assessment Score).
PKU screening	●	Newborns
Ocular (eye) medication to prevent blindness	●	Newborns
Prostate cancer screening (PSA)	●	Men ages 50 and older or age 40 with risk factors
Rh incompatibility test	●	Pregnant women
Sexually transmitted infections (STI) counseling	● ● ●	Sexually active women, annually; sexually active adolescents; and men at increased risk
Sexually transmitted infections (STI) screening	●	All sexually active adolescents.
Sickle cell disease screening	●	Newborns
Skin cancer prevention counseling to minimize exposure to ultraviolet radiation	● ● ●	Ages 10–24
Syphilis screening	● ● ●	Individuals at risk; pregnant women
Tobacco use/cessation interventions	● ●	All adults; pregnant women
Tobacco use prevention (counseling to prevent initiation)	●	School-age children and adolescents
Tuberculin test	●	Children and adolescents at risk
Ultrasound aortic abdominal aneurysm screening	●	Men ages 65–75 who have ever smoked
Vision screening (not complete eye examination)	●	Ages 3, 4, 5, 6, 8, 10, 12, 15 and 18 or as doctor advises

● = Men ● = Women ● = Children/adolescents

Other coverage: Your plan supplements the preventive care services listed above with additional services that are commonly ordered by primary care physicians during preventive care visits. These include services such as urinalysis, EKG, thyroid screening, electrolyte panel, Vitamin D measurement, bilirubin, iron and metabolic panels.

1. Subject to the terms of your plan's pharmacy coverage, certain drugs and products may be covered at 100%. Your doctor is required to give you a prescription, including for those that are available over-the-counter, for them to be covered under your pharmacy benefit. Cost sharing may be applied for brand-name products where generic alternatives are available.
2. Subject to the terms of your plan's medical coverage, breast-feeding equipment rental and supplies may be covered at the preventive level.
3. Examples include oral contraceptives; diaphragms; hormonal injections and contraceptive supplies (spermicide, female condoms); emergency contraception.
4. Subject to the terms of your plan's medical coverage, contraceptive products and services such as some types of IUD's, implants and sterilization procedures may be covered at the preventive level. Check your plan materials for details about your specific medical plan.

These preventive health services are based on recommendations from the U.S. Preventive Services Task Force (A and B recommendations), the Advisory Committee on Immunization Practices (ACIP) for immunizations, the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children and, with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov. This document is a general guide. Always discuss your particular preventive care needs with your doctor.

Exclusions

This document provides highlights of preventive care coverage generally. Some preventive services may not be covered under your plan. For example, immunizations for travel are generally not covered. Other non-covered services/supplies may include any service or device that is not medically necessary or services/supplies that are unproven (experimental or investigational). For the specific coverage terms of your plan, refer to your plan's summary pan document.

Federally Required Notices

Notice of Creditable Coverage

Prescription Drug Information for State of Illinois Medicare-Eligible Plan Participants

This Notice confirms that the State of Illinois Group Insurance Program has determined that the prescription drug coverage it provides is creditable. This means that your existing prescription coverage is on average as good as or better than the standard Medicare prescription drug coverage (Medicare Part D). You can keep your existing group prescription coverage and choose not to enroll in a Medicare Part D plan. Unless you qualify for low-income/extra-help assistance, you should not enroll in a Medicare Part D plan.

With this Notice of Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. However, you must remember that if you drop your entire group coverage through the State Employees Group Insurance Program and experience a continuous period of 63 days or longer without creditable coverage, you may be penalized if you enroll in a Medicare Part D plan later. If you choose to drop your State Employees Group Insurance coverage, the Medicare Special Enrollment Period for enrollment into a Medicare Part D plan is two months after the loss of creditable coverage.

If you keep your existing group coverage, it is not necessary to join a Medicare prescription drug plan this year. Plan participants who decide to enroll into a Medicare prescription drug plan; however, may need a personalized Notice of Creditable Coverage in order to enroll into a prescription plan without a financial penalty. Participants who need a personalized Notice may contact the State of Illinois Medicare Coordination of Benefits Unit at (800) 442-1300 or (217) 782-7007.

Summary of Benefits and Coverage (SBC) and Uniform Glossary

Under the Affordable Care Act, health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about a health plan's benefits and coverage. The regulation is designed to help you better understand and evaluate your health insurance choices.

The forms include a short, plain language Summary of Benefits and Coverage (SBC) and a uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment."

All insurance companies and group health plans must use the same standard SBC form to help you compare health plans. The SBC form also includes details, called "coverage examples," which are comparison tools that allow you to see what the plan would generally cover in two common medical situations. You have the right to receive the SBC when shopping for, or enrolling in, coverage or if you request a copy from your issuer or group health plan. You may also request a copy of the glossary of terms from your health insurance company or group health plan. All State health plan SBC's are available on the Benefits website.

Notice of Privacy Practices

The Notice of Privacy Practices have been updated on the Benefits website and were effective July 1, 2015. You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, we will post the revised Notice on our website at **www.benefitschoice.il.gov**.

Plan Participants (Members and Dependents) Eligible for Medicare

What is Medicare?

Medicare is health insurance for people 65 or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has the following parts to help cover specific services:

Medicare Part A

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home Health care

Part A coverage is premium-free for participants with enough earned credits based on their own work history or that of a spouse at least 62 years of age (when applicable) as determined by the Social Security Administration (SSA).

Medicare Part B

- Services from doctors and other health care providers
- Outpatient care
- Durable medical equipment
- Some preventative services

Part B coverage requires a monthly premium contribution. With limited exception, enrollment is required for participants who are retired or who have lost "current employment status" and are eligible for Medicare.

Medicare Part C

- Includes all benefits and services covered under Part A and Part B
- Usually includes Medicare prescription drug coverage (Part D) as part of the plan
- Run by Medicare-approved private insurance companies
- May include extra benefits and services

Part C coverage (known as Medicare Advantage) requires a monthly premium contribution. The State of Illinois offers a State-sponsored Medicare Advantage plan option that includes Part D coverage to eligible plan participants (see the box in this section titled **Total Retiree Advantage Illinois (TRAIL)**) for more information.

Medicare Part D

- Helps cover the cost of prescription drugs
- Run by Medicare-approved private insurance companies

Medicare Part D coverage requires a monthly premium contribution, unless the participant qualifies for extra-help assistance as determined by the SSA.

In order to apply for Medicare benefits, plan participants are instructed to contact their local SSA office or call (800) 772-1213. Plan participants may also contact the SSA via the internet at **www.socialsecurity.gov**

State of Illinois Medicare Requirements

Each plan participant must contact the SSA and apply for Medicare benefits upon turning the age of 65. If the SSA determines that a plan participant is eligible for Medicare Part A at a premium-free rate, the State requires that the plan participant accept the Medicare Part A coverage.

If the SSA determines that a plan participant is not eligible for premium-free Medicare Part A based on his/her own work history or the work history of a spouse at least 62 years of age (when applicable), the plan participant must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to the State of Illinois Medicare COB Unit to avoid a financial penalty. Plan participants who are ineligible for premium-free Medicare Part A benefits, as determined by the SSA, are not required to enroll into Medicare.

To ensure that healthcare benefits are coordinated appropriately and to prevent financial liabilities with healthcare claims, plan participants must notify the State of Illinois when they become eligible for Medicare and submit a copy of the Medicare identification card to the State of Illinois Medicare COB Unit. The Medicare COB Unit can be reached by calling (800) 442-1300 or (217) 782-7007.

Plan Participants Eligible for Medicare (cont.)

Members with Current Employment Status

Members (as well as any applicable dependents) who are actively working that become eligible for Medicare due to turning age 65 or due to a disability (under the age of 65) must accept the premium-free Medicare Part A coverage, but may delay the purchase of Medicare Part B. The State of Illinois Group Insurance Program will remain the primary insurance until the date the member retires or loses "current employment status" (such as no longer working due to a disability-related leave of absence). Upon such an event, Medicare Part B is required by the State.

Members without Current Employment Status

Members (as well as any applicable dependents) who are retired or who have lost current employment status (such as no longer working due to a disability related leave of absence) that are eligible for Medicare due to turning age 65 or due to a disability (under the age of 65) **are required to enroll in the Medicare Program**. In most cases, Medicare is the primary payer for health insurance claims over the State of Illinois Group Insurance Program.

Medicare Parts A and B Reduction

Failure to enroll and maintain enrollment in Medicare Parts A and B when Medicare is the primary payer will result in a reduction of benefits under the State of Illinois Group Insurance Program and will result in additional out-of-pocket expenditures for health-related claims.

Plan Participants Eligible for Medicare on the Basis of End-Stage Renal Disease (ESRD)

Plan participants of any age who are eligible for Medicare benefits based on End-Stage Renal Disease (ESRD) must contact the State of Illinois Medicare COB Unit for information regarding Medicare requirements and to ensure proper calculation of the 30-month coordination of benefit period.

Plan Participants with Additional Insurance

Plan participants that are actively working (or retired) with additional insurance (other than what is provided through the State of Illinois Group Insurance Program) must submit a copy of their insurance identification card along with the effective date of the other plan's coverage to the State of Illinois Medicare COB Unit in order to ensure the proper coordination of benefits for healthcare claims.

Plan participants can contact the State of Illinois Medicare COB Unit via phone at (800) 442-1300 or (217) 782-7007.

Total Retiree Advantage Illinois (TRAIL)
Medicare Advantage Program

Annuitants and survivors (as well as their covered dependents) who become enrolled in Medicare Parts A and B and meet all the criteria for enrollment in the Medicare Advantage Program will be notified of the TRAIL Open Enrollment Period by the Department of Central Management Services. These members will be required to choose a Medicare Advantage plan or opt out of State coverage (which includes health, behavioral health, prescription and vision coverage) in the fall with an effective date of January 1, 2017. For more information regarding the Medicare Advantage 'TRAIL' Program, go to:

www.cms.illinois.gov/thetrail

Behavioral Health Services

Quality Care Health Plan
Magellan Behavioral Health is the plan administrator for behavioral health services under the Quality Care Health Plan (QCHP). Behavioral health services are included in an enrollee's annual medical plan year deductible and annual out-of-pocket maximum. Covered services for behavioral health which meet the plan administrator's medical necessity criteria are paid in accordance with the QCHP benefit schedule for in-network and out-of-network providers. For authorization procedures, see the Benefits Handbook or call Magellan at (800) 513-2611. Please contact Magellan for specific benefit information.

Managed Care Plans (HMO and OAP Plans)
Behavioral health services are provided under the managed care plans. Covered services for behavioral health must meet the managed care plan administrator's medical necessity criteria and will be paid in accordance with the managed care benefit schedules. Please contact the managed care plan for specific benefit information.

Employee Assistance Program

There are two separate programs that provide valuable resources for support and information during difficult times for active employees and their dependents: the Employee Assistance Program (EAP) and the Personal Support Program (PSP). The EAP benefit applies to employees only and does not apply to annuitants.

The Employee Assistance Program (EAP) is for active employees NOT represented by the collective bargaining agreement between the State and AFSCME Council 31. These employees must contact the EAP administered by Magellan Behavioral Health.

The Personal Support Program (PSP) is for bargaining unit employees represented by AFSCME Council 31 and covered under the master contract agreement between the State of Illinois and AFSCME. These employees must access PSP services through the AFSCME Personal Support Program.

Both programs are free, voluntary and provide problem identification, counseling and referral services to employees and their covered dependents regardless of the health plan chosen. All calls and counseling sessions are confidential, except as required by law. No information will be disclosed unless written permission is received from the employee. Management consultation is available when an employee's personal problems are causing a decline in work performance. See page 37 for website and other contact information.

To access website links to plan administrators, visit the Benefits website at www.benefitschoice.il.gov.

Prescription Benefit

Plan participants enrolled in any State health plan have prescription drug benefits included in the coverage. Plan participants who have additional prescription drug coverage, such as Medicare or TRICARE, should contact their plan's prescription benefit manager (PBM) for coordination of benefits (COB) information. **Copayments and a prescription deductible apply to each plan participant each plan year for all health plans.** Please note that when a pharmacy dispenses a brand drug for any reason and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the brand copayment. This is known as the dispense as written (DAW) penalty.

To compare formulary lists, cost-savings programs and to obtain a list of pharmacies that participate in the various health plan networks, plan participants should visit the website of each health plan they are considering.

Fully-insured managed care plans (i.e., BlueAdvantage HMO, Health Alliance HMO, Coventry Health Care HMO and HMO Illinois) use their own prescription benefit manager (PBM) to administer prescription benefits. Members who elect one of these plans must utilize a pharmacy participating in the plan's pharmacy network or the full retail cost of the medication will be charged. Partial reimbursement may be provided if the plan participant files a paper claim with the health plan.

Most plans do not cover over-the-counter drugs or drugs prescribed by medical professionals (including dentists) other than the plan participant's primary care physician (PCP). Drugs prescribed by a specialist would be covered provided that the plan participant was referred to the specialist by their PCP. **Members should direct prescription benefit questions to the respective health plan administrator.**

Self-insured plans (i.e., HealthLink OAP and Coventry Health Care OAP and the Quality Care Health Plan (QCHP)) have prescription benefits administered through the state-contracted prescription benefit manager (PBM), CVS/caremark. In order to receive the best value, plan participants enrolled in one of these plans should carefully review the various options through which they may receive their medication. Most drugs purchased with a prescription from a physician or a dentist are covered; however, over-the-counter drugs are not covered, even if purchased with a prescription.

Formulary Lists: All prescription medications are compiled on a preferred formulary list (i.e., drug list) maintained by each health plan's prescription benefit manager (PBM). Formulary lists categorize drugs in three levels: generic, preferred brand and nonpreferred. Each category has a different copayment amount. Coverage for specific prescription drugs may vary depending upon the health plan. **Formulary lists are subject to change any time during the plan year.** Therefore, when a prescribed medication the plan participant is currently taking is reclassified into a different formulary list category or is excluded either the health plan or the PBM will notify plan participants by mail. If a formulary change occurs, plan participants should consult with their physician to determine if a change in prescription is appropriate.

Self-insured Plans Prescription Benefit

(QCHP, HealthLink OAP and Coventry Health Care OAP)

CVS/caremark is the prescription benefit manager (PBM) for the Quality Care Health Plan (QCHP), HealthLink OAP and Coventry OAP plans. CVS/caremark has an extensive network of more than 68,000 pharmacies, including independent pharmacies and chain pharmacies, such as Walgreens, Walmart and Target, as well as CVS. For a complete list of pharmacies, go to the CVS/caremark website or contact the customer service number.

Nonmaintenance Medication

In-Network Pharmacy - Retail pharmacies that contract with CVS/caremark and accept the copayment for medications are referred to as in-network pharmacies. Plan participants who use an in-network pharmacy must present their prescription ID card/number or they will be required to pay the full retail cost. If, for any reason, the pharmacy is not able to verify eligibility (submit claim electronically), the plan participant must submit a paper claim to CVS/caremark. The maximum supply of **nonmaintenance medication** allowed at one fill is 60 days, although two copayments will be charged for any prescription that exceeds a 30-day supply.

Out-of-Network Pharmacy - Pharmacies that do not contract with CVS/caremark are referred to as out-of-network pharmacies. In most cases, a plan participant's prescription drug costs will be higher when an out-of-network pharmacy is used. If a medication is purchased at an out-of-network pharmacy, the plan participant must pay the full retail cost at the time the medication is dispensed. Reimbursement of eligible charges may be obtained by submitting a paper claim and the original prescription receipt to the PBM. Reimbursement will be provided at the applicable brand or generic in-network price minus the appropriate in-network copayment and/or deductible. Claim forms are available by visiting the Benefits website or the CVS/caremark website.

Foreign Pharmacy - Pharmacies that are located outside of the United States (except network pharmacies in Puerto Rico) are considered foreign pharmacies and are therefore out-of-network. In most cases, a plan participant's prescription drug costs will be higher when an out-of-country pharmacy is used. Reimbursement will be based on a 30 or 60 day fill only. If a medication is purchased at a foreign pharmacy, the plan participant must pay the full retail cost at the time the medication is dispensed. Reimbursement of eligible charges may be obtained by submitting a paper claim and required documentation as prescribed by CVS/caremark. Reimbursement will be based on the exchange rate **on the date of purchase** and in accordance with applicable plan design. **Prior authorizations may still be needed for certain drugs.** Reimbursement claim forms are available by visiting the Benefits website or the CVS/caremark website.

Maintenance Medication

The Maintenance Medication Program was developed to provide an enhanced benefit to plan participants who use **maintenance medications.** Maintenance medication is medication that is taken on a regular basis for conditions such as high blood pressure and high cholesterol. To determine whether a medication is considered a maintenance medication, contact a pharmacist or contact CVS/caremark. A list of pharmacies participating in the Maintenance Network is available at **www.benefitschoice.il.gov** or the CVS/caremark website. When plan participants use the Maintenance Network for maintenance medications, they will receive a **90-day supply of medication (equivalent to 3 fills) for only two and a half copayments.**

The Maintenance Network is a network of retail pharmacies that contract with the PBM to accept the copayment amount for maintenance medication. Pharmacies in this network may also be an in-network retail pharmacy as described in the Nonmaintenance Medication section.

Plan participants will be charged a **penalty in an amount equal to double the prescription**

copayment if they obtain a maintenance medication from a non-maintenance network pharmacy or a prescription for a maintenance medication that is written for a 30-day supply instead of a 90-day supply.

The penalty will be forgiven only for the first two 30-day fills (or first 60-day fill), but will apply thereafter.

Mail Order Pharmacy

The mail order pharmacy provides participants the opportunity to receive medications directly at their home. **Both maintenance and nonmaintenance medications may be obtained through the mail order process.**

To utilize the mail order pharmacy, plan participants must submit an original prescription from the attending physician. For maintenance medication, prescriptions should be written for a 90-day supply, and include up to three 90-day refills, totaling one year of medication. The original prescription must be attached to a completed mail order form and sent to the address indicated on the form. When plan participants use the mail order pharmacy, they will receive a **90-day supply of medication (equivalent to 3 fills) for only two and a half copayments.** Order forms and refills can be obtained by contacting CVS/caremark.

Prescription Drug Step Therapy

Members who have their prescription benefits administered through QCHP or one of the OAP self-insured plans will be subject to prescription drug step therapy (PDST) for specific drugs. PDST requires the plan participant to first try one or more specified drugs to treat a particular condition before the plan will cover another (usually more expensive) drug that their doctor may have prescribed. PDST is intended to reduce costs to both the member and the plan by encouraging the use of medications that are less expensive but can still treat the plan participant's condition effectively.

CVS/caremark: (877) 232-8128
TDD/TTY: (800) 231-4403
Website: www.caremark.com

Dental Plan

All members and enrolled dependents have the same dental benefits available regardless of the health plan selected. During the Benefit Choice Period, members have the option to add or drop dental coverage. **The election to add or drop dental coverage will remain in effect the entire plan year, without exception.**

Dental Benefit

The Quality Care Dental Plan (QCDP) is a dental plan that offers a comprehensive range of benefits administered by Delta Dental of Illinois. The QCDP reimburses only those services listed on the Dental Schedule of Benefits (available on the Benefits website). Listed services are reimbursed at a predetermined maximum scheduled amount. Each plan participant is subject to an annual plan deductible for all dental services, except those listed in the Schedule of Benefits as 'Diagnostic' or 'Preventive.' The annual plan year deductible is $175 per participant per plan year. Once the annual deductible has been met, each plan participant is subject to a maximum annual dental benefit. Each plan participant has a maximum dental benefit of $2,500 (including orthodontia) when services are rendered by an in-network provider; however; participants who use an out-of-network provider are limited to a maximum benefit of $2,000 (including orthodontia). **For Example:** If a participant's out-of-network plan year maximum is met, there would be no further coverage available for out-of-network services; however, the participant would be allowed to utilize an in-network provider to exhaust the $500 remaining under the $2,500 in-network plan year maximum.

Plan participants enrolled in the dental plan can choose any dental provider for services; however, plan participants may pay less out-of-pocket when they receive services from a network dentist. There are two separate networks of dentists that a plan participant may utilize for dental services in addition to out-of-network providers: the Delta Dental PPO℠ network and the Delta Dental Premier℠ network.

Deductible and Plan Year Maximum

Annual Deductible for Preventive Services	N/A
Annual Deductible for All Other Covered Services	$175
Plan Year Maximum Benefit*	
In-Network Plan Year Maximum Benefit	$2,500
Out-of-Network Plan Year Maximum Benefit	$2,000

- **Delta Dental PPO℠ Network** If you receive services from a PPO-level dentist you can maximize your dental benefits and minimize your out-of-pocket expenses because these providers accept a lower negotiated PPO fee (less any deductible). If the PPO fee is lower than the amount listed on the Schedule of Benefits, the PPO dentist cannot bill you for the difference.
- **Delta Dental Premier℠ Network** If you receive services from a Premier-level dentist, your out-of-pocket expenses may also be less because Premier providers accept the allowed Premier-level fee (less any deductible). If the allowed fee is lower than the amount listed on the Schedule of Benefits, the Premier dentist cannot bill you for the difference.
- **Out-of-Network** If you receive services from a dentist who does not participate in either the PPO or Premier network, you will receive benefits as provided by the Schedule of Benefits. You will likely pay more than you would if you went to a Delta Dental network dentist. Out-of-network dentists will charge you for the difference between their submitted fee and the amount listed on the Schedule of Benefits.

It is strongly recommended that plan participants obtain a pretreatment estimate for any service over $200, regardless of whether that service is to be received from an in-network or an out-of-network provider. Failure to obtain a pretreatment estimate may result in unanticipated out-of-pocket costs. A pretreatment estimate is a review by Delta Dental of a dental provider's proposed treatment, including diagnostic, x-ray and laboratory reports, as well as the expected charges. This treatment plan is sent to Delta Dental for verification of eligible benefits. Obtaining a pretreatment estimate to verify coverage will help you make decisions regarding your dental services and help you avoid unanticipated out-of-pocket costs. Questions regarding a pretreatment estimate can be addressed by Delta Dental.

* Orthodontics + all other covered services = Plan Year Maximum Benefit

Dental Plan (cont.)

Provider Payment

If you use a Delta Dental network dentist, you will not have to pay the dentist at the time of service (with the exception of applicable deductibles, charges for noncovered services, charges over the amount listed on the Schedule of Benefits and/or amounts over the annual maximum benefit).

Network dentists will automatically file the dental claim for their patients. Out-of-network dentists can elect to accept assignment from the plan or may require other payment terms. Participants who use an out-of-network dentist may have to pay the entire bill at the time of service and/or file their own claim form depending on the payment arrangements the plan participant has with their dentist.

Example of PPO, Premier and Out-of-Network Dentist Payments (this is a hypothetical example only and assumes the deductible has been met).

Delta Dental PPO Dentist*		Delta Dental Premier Dentist*		Out-of-Network Dentist	
Dentist submitted fee	$1,000	Dentist submitted fee	$1,000	Dentist submitted fee	$1,000
PPO maximum allowed fee	$600	Premier maximum allowed fee	$900	No negotiated fee	n/a
Schedule of Benefits amount	$781	Schedule of Benefits amount	$781	Schedule of Benefits amount	$781
Your Out-of-Pocket Cost	$0	Your Out-of-Pocket Cost	$119	Your Out-of-Pocket Cost	$219

* When utilizing a PPO or Premier dentist, if the maximum allowed fee is greater than the amount listed on the Schedule of Benefits, the network dentist can bill the member the difference between the two amounts.

Child Orthodontia Benefit

The child orthodontia benefit is available only to children who begin treatment prior to the age of 19. The maximum lifetime benefit for child orthodontia is $2,000 for members utilizing an in-network provider. Services obtained at an out-of-network orthodontia provider will have a lifetime maximum benefit of $1,500. This lifetime maximum is based on the length of treatment (see 'Length of Orthodontia Treatment' chart below). This lifetime maximum applies to each plan participant regardless of the number of courses of treatment. **Note:** The annual plan year deductible must be satisfied each plan year that the plan participant is receiving orthodontia treatment unless it was previously satisfied for other dental services incurred during the plan year. This may reduce the maximum benefit payable for orthodontia treatment.

Length of Orthodontia Treatment	Maximum Benefit	
0 - 36 Months	In-network $2,000	Out-of-network $1,500
0 - 18 Months	In-network $1,820	Out-of-network $1,364
0 - 12 Months	In-network $1,040	Out-of-network $780

Prosthodontic Limitations

(Prosthodontics include full dentures, partial dentures, implants and crowns)

- Prosthodontics to replace missing teeth are covered only for teeth that are lost while the plan participant is covered by QCDP.
- Multiple procedures are subject to limitations. Please refer to the Dental Schedule of Benefits PRIOR to the start of any procedure to clarify coverage limitations.

Plan participants can access QCDP network information, explanation of benefits (EOB) statements and other valuable information online by registering with Delta Dental of Illinois Member Connection.

Delta Dental: (800) 323-1743
TDD/TTY: (800) 526-0844
Website: http://soi.deltadentalil.com

Vision Plan

Vision coverage is provided at no additional cost to members enrolled in any of the health plans. All members and enrolled dependents have the same vision coverage regardless of the health plan selected. Eye exams and replacement lenses are covered once every 12 months from the last date the exam benefit was used. Standard frames are available once every 24 months from the last date used. Copayments are required.

Service	Network Provider Benefit	Out-of-Network** Provider Benefit	Benefit Frequency
Eye Exam	$25 copayment	$30 allowance	Once every 12 months
Spectacle Lenses* (single, bifocal and trifocal)	$25 copayment	$50 allowance for single vision lenses $80 allowance for bifocal and trifocal lenses	Once every 12 months
Standard Frames	$25 copayment (up to $175 retail frame cost; member responsible for balance over $175)	$70 allowance	Once every 24 months
Contact Lenses (All contact lenses are in lieu of spectacle lenses)	$120 allowance	$120 allowance	Once every 12 months

* Spectacle Lenses: Plan participant pays any and all optional lens enhancement charges. Network providers may offer additional discounts on lens enhancements and multiple pair purchases.
** Out-of-network claims must be filed within one year from the date of service.

EyeMed Vision Care: (866) 723-0512
TDD/TTY: (800) 526-0844
Website: www.eyemedvisioncare.com/stil

Life Insurance Plan*

Basic Life insurance is provided at no cost to annuitants and active employees. This term life coverage is provided in an amount equal to the annual salary of active employees. The Basic Life amount for annuitants under age 60 is equal to the annual salary as of the last day of active State employment. For annuitants age 60 or older, the Basic Life amount is $5,000. The life insurance plan offers eligible members the option to purchase additional life insurance to supplement the Basic Life insurance provided by the State.

Member Optional Life

Member Optional Life coverage is available to eligible members. Annuitants under age 60 and active employees can elect coverage in an amount equal to 1-8 times their Basic Life amount; annuitants age 60 and older can elect 1-4 times their Basic Life amount. Members enrolled with Member Optional Life coverage should review the chart on page 7 to be aware of rate variations among age groups. Rate changes due to age go into effect the first pay period following the member's birthday.

The maximum benefit allowed for Member Optional Life plus Basic Life coverage is $3,000,000.

Accidental Death & Dismemberment

Accidental Death and Dismemberment (AD&D) coverage is available to eligible members in either (1) an amount equal to their Basic Life amount or (2) the combined amount of their Basic and Member Optional Life, subject to a total maximum of five times the Basic Life insurance amount or $3,000,000, whichever is less.

Spouse Life

Spouse Life coverage is available in a lump sum amount of $10,000 for the spouse of annuitants under age 60 and active employees. Spouse Life coverage decreases to $5,000 for annuitants age 60 and older. A corresponding premium applies.

Child Life

Child Life coverage is available in a lump sum amount of $10,000 for each child. The monthly contribution for Child Life coverage applies to all dependent children regardless of the number of children enrolled. Eligible children include:

- Children age 25 and under
- Children in the Disabled category

Statement of Health

Adding/increasing Member Optional Life, as well as adding Spouse and/or Child Life coverage, is subject to prior approval by the life insurance plan administrator, Minnesota Life Insurance Company. Members must complete and submit a statement of health form to Minnesota Life for review.

Beneficiary Designations

You should periodically review all beneficiary designations and make the appropriate updates. Remember, you may have death benefits through various state-sponsored programs, each having a separate beneficiary form:

- State of Illinois life insurance
- Retirement benefits
- Deferred Compensation

* Deferred Annuitants and Survivors have different life insurance benefits. Details are provided in the Retiree, Annuitant and Survivor Benefits Handbook available on the Benefits website.

Minnesota Life Insurance Co.: (888) 202-5525
TDD/TTY: (800) 526-0844
Website: https://web1.lifebenefits.com/lbwcm/pd/illinois

Flexible Spending Accounts (FSA)

Employee Benefit Only - Does NOT Apply to Annuitants

During the Benefit Choice Period, employees may enroll in a Flexible Spending Account (FSA) with an effective date of July 1, 2016. The great advantage is that you pay no federal or employment taxes on your contributions. For example, if you put in $1,000 you save $300 ($1,000 x 30% (you pay in taxes) = $300) over the course of the plan year.

FSA plan elections do not automatically carry over each year. You must enroll using the MCAP and/or DCAP forms available at **www.benefitschoice.il.gov** to participate. The first deduction for an FSA enrollment will be taken on a pretax basis from the first paycheck issued in July. Employees should carefully review their paycheck to verify the deduction was taken correctly. **If you do not see the deduction on your paycheck stub, please contact your payroll office immediately.**

Medical Care Assistance Plan (MCAP)

What is it? The Medical Care Assistance Plan (MCAP) is a program that allows you to set aside money, before taxes, from your paycheck to pay for health-related expenses not covered by insurance. If you, or someone in your family (i.e., spouse and/or eligible dependents) goes to the doctor or dentist, takes medication or wears glasses, whether you have insurance or not, MCAP may save you money. Please note that dependents must qualify under the Internal Revenue Code in order for their healthcare expenses to be eligible for reimbursement. Refer to the Flexible Spending Accounts Reference Guide on the Benefits website for IRS dependent eligibility requirements.

How much should I contribute? Contributions depend on your family's medical expenses which include copayments and deductibles associated with doctor's visits, prescriptions, medically-necessary orthodontia (e.g., braces), vision exams and surgeries (e.g., LASIK surgery). The maximum annual amount you may elect is $2,550. The minimum monthly amount for which an employee may enroll is $20; the maximum monthly amount is $212.50 (or $283.33 for university employees paid over 9 months).

MCAP Rollover

MCAP Minimum & Maximum Rollover Guidelines

The State of Illinois offers an MCAP plan that permits up to $500 of unused funds to be carried over to the next year in compliance with IRS Notice 2013-71. **New for the F2017 plan year:** IRS Notice 2015-87 will be implemented by the State for FY2017, allowing employee participation in the rollover benefit only if the employee enrolls in the MCAP for the next plan year.

Maximum $500 MCAP Rollover – MCAP participants who have a balance remaining in their MCAP account after all run-out claims have been processed, will have up to $500* of that account balance automatically rolled over to their next plan year account. This rollover amount will be added to the FY2017 available balance on or about October 7, 2016, only if the participant has re-enrolled for FY2017.

For example, Employee A re-enrolls in MCAP for the FY2017 plan year for the maximum amount of $2,550. On October 7, 2016, the balance remaining in their MCAP account is $350; therefore, **for the FY2017 plan year** they will have a total of $2,900 in their MCAP account to use during the FY2017 plan year.

All eligible expenses incurred on or after July 1, 2016, will be eligible for reimbursement using the rollover funds. **Participants who do not re-enroll for the new plan year will forfeit any amount eligible for rollover.**

* This rollover amount is for MCAP accounts only and does not apply to DCAP accounts.

Examples of expenses you cannot claim:

- Cosmetic services, vitamins, supplements
- Insurance premiums
- Vision warranties and service contracts
- Over-the-counter medicines and drugs are not eligible for reimbursement without a prescription

How do I use my MCAP account? Employees who are enrolled in MCAP will be issued a stored-value debit card at no cost. The card may be used to pay for medical expenses and eligible over-the-counter medical-related purchases. Documentation will be required to substantiate certain expenses paid with the debit card; therefore, you should review your online account carefully to ensure you are aware of the documentation requirements. Employees choosing not to use the debit card may complete and submit a paper claim form for reimbursement of eligible expenses.

What is the deadline to submit MCAP claims for reimbursement? You will have until the end of the run-out period, September 30, 2017, to submit claims for expenses that were incurred from July 1, 2016, through June 30, 2017.

Dependent Care Assistance Plan (DCAP)

The Dependent Care Assistance Plan (DCAP) is for the reimbursement of eligible child care expenses, such as daycare.* DCAP cannot be used for dependent healthcare expenses (employees interested in having their dependent's health-related expenses reimbursed through a pretax program should refer to the Medical Care Assistance Plan (MCAP) on page 32). In situations where parents are legally separated or divorced, only the custodial parent can enroll in DCAP. The custodial parent is defined by the IRS as the person who has the child the most nights during the calendar year. See IRS Publication 503 for more information.

What is it? The Dependent Care Assistance Plan (DCAP) is a program that allows you to set aside money, before taxes, from your paycheck to pay primarily for **child care expenses* of dependent children 12 years and under.** If you (and your spouse, if married), work full-time and pay for daycare, day camp or after-school programs, then DCAP may save you money. Please note that if you claim the dependent care tax credit, the credit will be reduced, dollar for dollar, by the amount you contribute to DCAP. Also, depending on your household income, it might be advantageous to claim child care expenses on your federal income tax return instead of using DCAP. You cannot claim the expenses on your tax return and use DCAP. Please ask your tax adviser which plan is best for you.

How much should I contribute? Contributions depend on household needs—think about how much you spend on child care every year. Will you use daycare or a private nanny? Perhaps your child is going to nursery school or day camp this year. The maximum annual amount you may elect is $5,000. The minimum monthly amount for which an employee may enroll is $20; the maximum monthly amount is $416.66 (or $555.54 for university employees paid over 9 months).

Examples of expenses you cannot claim:

- Overnight camp
- Daycare provided by another dependent
- Daycare provided "off the books"
- Kindergarten tuition
- Private primary school tuition
- Before and after-school care expenses for dependents age 13 and older.

You have until September 30, 2017, to submit claims for services incurred from July 1, 2016, through June 30, 2017; otherwise, any money left in your account will be forfeited.

ConnectYourCare: (888) 469-3363
Fax: (443) 681-4602
Website: www.connectyourcare.com

Special Note Regarding DCAP Reimbursement for Summer Day Camps

Employees who enroll children in a summer day camp should calculate their FY2017 daycare expenses and annual contribution carefully. Since the FY2016 plan year ends June 30th, any day camp expenses incurred during June 2016 will not be eligible for reimbursement through your FY2017 DCAP. **For FY2017, the summer months of July and August 2016, as well as June 2017, will be eligible for reimbursement.**

* In addition to child care, DCAP can be used to pay for the dependent care expenses for any individual living with you that is physically or mentally unable to care for themselves and is eligible to be claimed as a dependent on your taxes. Refer to the Internal Revenue Code to ensure your dependent qualifies as a tax dependent before enrolling in this program.

Program Initiatives

Smoking Cessation Program

Eligible plan participants are entitled to receive a rebate towards the cost of a smoking cessation program. The maximum rebate is $200, limited to one per plan year and available only upon completion of a smoking cessation program. Please note that many managed care plans offer smoking cessation programs separate from the State's Smoking Cessation Program. Employees who utilize a smoking cessation program through their managed care plan are not eligible for the Smoking Cessation Program benefit through CMS. Contact the managed care plan for more information regarding their smoking cessation program options and limitations.

Adoption Benefit Program

Recognizing adoption as a meaningful and viable way to build a family, CMS provides an Adoption Benefit Program to assist employees who adopt a child. To encourage adoption, especially of children who traditionally wait longer for families, the Adoption Benefit Program will reimburse eligible employees for some adoption expenses.

Disease Management Programs

Disease Management Programs are utilized by all of the State's health plans as a way to improve the health of plan participants. Members and dependents identified with certain risk factors indicating diabetes, cardiac health and many other chronic health conditions will be contacted by the medical plans to participate in these programs. These **highly confidential programs** are based upon certain medical criteria and provide:

- Healthcare support available 24-hours-a-day, 7-days-a-week with access to a team of registered nurses (RNs) and other qualified health clinicians;
- Wellness tools, such as reminders of regular health screenings;
- Educational materials pertaining to your health condition, including identification of anticipated symptoms and ways to better manage these conditions;
- Valuable information and access to discounted services from weight-loss programs.

Weight-Loss Benefit

As a commitment to an employee's overall wellness, eligible plan participants are entitled to receive a rebate towards the cost of an approved weight-loss program. The maximum rebate is $200 once every three plan years. Employees who utilize a weight-loss program are eligible for the weight-loss benefit through CMS.

For more information regarding adoption eligibility, the weight-loss benefit or smoking cessation program, refer to **www.benefitschoice.il.gov.**

Wellness Offerings

Be Well, Get Well, Stay Well

The State offers many valuable wellness programs to help keep our members healthy and help unhealthy members get healthier. The goal is for all members to lead better, more satisfying lives.

Our Wellness Program

The State is highlighting its current wellness program to provide even more assistance to you. The program focuses on improving lifestyle choices, including eating healthier, being more physically active, ending tobacco use, managing stress more effectively, and getting more sleep. The goal is to help you avoid chronic health problems (or help stabilize/improve them, if applicable), such as diabetes, heart disease, high blood pressure and high cholesterol.

What You Can Do Now

Steps you can take to be healthier and live better:

- Step 1: Get a checkup. It is vitally important to have a preventive health exam each year, including (as applicable based on your age and gender) a Pap smear, prostate exam, mammogram, colonoscopy, cancer screening and immunizations. Your health plan covers many preventive services at no cost to you, as required under Federal Health Care Reform laws.
- Step 2: Take advantage of your medical plan's resources. Many State-offered medical plans have valuable wellness resources such as health information libraries, online health coaching, dedicated nurse phone lines and wellness publications. Visit your plan's website to find out what's available to you.
- Step 3: Know your numbers, know your risks. A smart step to getting healthier and staying that way, is to…
  - …Know your numbers: Get biometric screenings from your doctor. These are simple and quick tests that measure your blood pressure, pulse rate, blood glucose (sugar), total cholesterol, body mass index (BMI), height and weight. You can get them when you go for an annual physical.
  - …Take a Health Risk Assessment (HRA): Complete a private, confidential HRA on your medical plan's website. It asks basic health-related questions like, "Did you get a flu shot?" and "Do you wear a seat belt?" There are no right or wrong answers. The information you provide—and HRA results—is not shared with the State. You'll get instant results after you complete an HRA, including a personal action plan. (Using your biometric screening information will give you the most accurate results.) Share your results and action plan with your doctor. Discuss with your physician ways you can maintain good health or improve your health.

Plan Administrators

Who to contact for information

Health Plan Administrators	Toll-Free Telephone Number	TDD/TTY Number	Website Address
BlueAdvantage HMO	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois
Coventry Health Care HMO	(800) 431-1211	(217) 366-5551	www.chcillinois.com
Coventry Health Care OAP	(800) 431-1211	(217) 366-5551	www.chcillinois.com
Health Alliance HMO	(800) 851-3379	(800) 526-0844	www.healthalliance.org/stateofillinois
HealthLink OAP	(800) 624-2356	(800) 624-2356 ext. 6280	www.healthlink.com/illinois_index.asp
HMO Illinois	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois
Quality Care Health Plan (Cigna)	(800) 962-0051	(800) 526-0844	www.cigna.com/stateofil

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
Vision Plan	EyeMed Out-of-Network Claims P.O. Box 8504 Mason, OH 45040-7111	(866) 723-0512 (800) 526-0844 (TDD/TTY)	www.eyemedvisioncare.com/stil
Quality Care Dental Plan (QCDP) Administrator	Delta Dental of Illinois Group Number 20240 P.O. Box 5402 Lisle, IL 60532	(800) 323-1743 (800) 526-0844 (TDD/TTY)	http://soi.deltadentalil.com
Life Insurance Plan	Minnesota Life Insurance Company 536 Bruns Lane, Unit 3 Springfield, IL 62702	(888) 202-5525 (800) 526-0844 (TDD/TTY)	https://web1.lifebenefits.com/lbwcm/pd/illinois
Flexible Spending Accounts (FSA) Program	ConnectYourCare P.O. Box 622317 Orlando, FL 32862-2317	(888) 469-3363 (800) 526-0844 (TDD/TTY) (443) 681-4602 (fax)	www.connectyourcare.com
Commuter Savings Program (CSP)	Commuter Check Direct Claims Administrator 320 Nevada Street Newton, MA 02460	(888) 235-9223 (844) 878-0594 (TDD/TTY)	www.CommuterCheckDirect.com
Health/Dental Plans, Medicare COB Unit, FSA and CSP Unit, Premium Collection Unit, Life Insurance and the Benefit Programs for Adoption, Smoking Cessation and Weight Loss Benefit	CMS Group Insurance Division 801 South 7th Street P.O. Box 19208 Springfield, IL 62794-9208	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)	www.benefitschoice.il.gov

Plan Administrators

Who to contact for information

Plan Component	Contact For	Administrator's Name and Address	Customer Service Contact Information
QCHP Medical Plan Administrator	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and predetermination of benefits	Cigna QCHP Group #3181456 Cigna HealthCare P.O. Box 182223 Chattanooga, TN 37422-7223	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) www.cigna.com/stateofil
QCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Noncompliance penalty of $800 applies (out-of-network only)	Cigna QCHP Group #3181456	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY)
Prescription Drug Plan Administrator QCHP (1400SD3) Coventry OAP (1400SCH) HealthLink OAP (1400SCF)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	CVS/caremark Group Number: 1400SD3 1400SCH, 1400SCF Paper Claims: CVS/caremark P.O. Box 52136 Phoenix, AZ 85072-2136 Mail Order Prescriptions: CVS/caremark P.O. Box 94467 Palatine, IL 60094-4467	(877) 232-8128 (nationwide) (800) 231-4403 (TDD/TTY) www.caremark.com
QCHP Behavioral Health Administrator	Notification, authorization, claim forms and claim filing/resolution for behavioral health services	Magellan Behavioral Health QCHP Group #3181456 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com
Employee Assistance Program (EAP)	Confidential assistance and assessment services	Magellan Behavioral Health -For Non-AFSCME represented employees-	(866) 659-3848 (nationwide) (800) 456-4006 (TDD/TTY) www.MagellanHealth.com
Personal Support Program (PSP – AFSCME EAP)	Confidential assessment and assistance services	AFSCME Council 31 -For AFSCME represented employees-	(800) 647-8776 (statewide) (800) 526-0844 (TDD/TTY) www.afscme31.org

DISCLAIMER

The State of Illinois intends that the terms of this plan are legally enforceable and that the plan is maintained for the exclusive benefit of Members. The State reserves the right to change any of the benefits, program requirements and contributions described in this Benefit Choice Options Booklet. This Booklet is intended to supplement the Benefits Handbook. If there is a discrepancy between the Benefit Choice Options Booklet, the Benefits Handbook and state or federal law, the law will control.

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